

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 06452 357

1. PLACE OF DEATH- COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Md.</u> COUNTY <u>Worcester</u>	
CITY (If outside corporate limits, write RURAL, and give nearest town) <u>Snow Hill</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill</u>	
TOWN <u>Snow Hill</u>		TOWN <u>Snow Hill</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS <u>Rt 2 Indian town</u>	
3. NAME OF DECEASED (First) <u>George</u> (Middle) <u>L. Brunning</u> (Last) <u>Law</u>		4. DATE OF DEATH (Month) <u>June</u> (Day) <u>15</u> (Year) <u>1951</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>	8. DATE OF BIRTH <u>July 23, 1890</u>
9. AGE last birthday <u>60</u> yrs.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm Overseer</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Canning Industry</u>	11. BIRTHPLACE (State or foreign country) <u>Berlin Md Rt 2</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	13. FATHER'S NAME <u>Cyrus J. Brunningham</u>	14. MOTHER'S MAIDEN NAME <u>Elizabeth Henderson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS <u>Mrs. H. L. Brunningham Snow Hill Md</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Arteriosclerotic Myocarditis

INTERVAL BETWEEN ONSET AND DEATH

unknown

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Coronary Thrombosis

1 day

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

none

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒ (STATE)

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from June 13, 1951, to June 15, 1951, that I last saw the deceased alive on June 15, 1951, and that death occurred at 7:00 P.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>6/18/51</u>	<u>Evergreen</u>	<u>Berlin</u>	<u>Md</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>6/16/51</u>	<u>Rebay Smith</u>	<u>Dr. W. A. Bunney</u>	<u>Berlin Md</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 19 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 350

1. PLACE OF DEATH: COUNTY Worcester MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Worcester	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Pocomoke		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Pocomoke	
HOSPITAL OR INSTITUTION OR STREET ADDRESS RFD 2		STREET ADDRESS (If rural, give location) RFD 2	
3. NAME OF DECEASED (Type or Print)	(First) Martha	(Middle) Ellen	(Last) Coulbourne
4. DATE OF DEATH	(Month) June	(Day) 23	(Year) 1951
5. SEX Female	6. COLOR OR RACE Colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widow	8. DATE OF BIRTH March 6 1862
9. AGE last birthday 89 yrs.		10. BIRTHPLACE (State or foreign country) Maryland	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME John Cluff		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unknown) No		16. SOCIAL SECURITY No. None	
17. INFORMANT AND ADDRESS Lewis Coulbourne, Pocomoke, Md.			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH.

Immediate cause

Cerebral Hemorrhage

INTERVAL BETWEEN ONSET AND DEATH

5 days

Antecedent cause(s)

Arterio-sclerotic Cardio-Vas. Dis

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

Senility

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from **Jan. 51**, 19**51**, to **June 23**, 19**51**, that I last saw the deceased alive on **June 22**, 19**51**, and that death occurred at **5:15** p.m. from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	6/25/51	Unionville ME Cemetery	Pocomoke, Md.	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
June 25 1951	Anne E. White	Henry H. Watson	Pocomoke, Md.	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JUN 26 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 351

06454

1. PLACE OF DEATH COUNTY <u>Frederick</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md.</u> COUNTY <u>Frederick</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Newark</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Newark</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>R.D.</u>		STREET ADDRESS (If rural give location) <u>R.D.</u>	
3. NAME OF DECEASED (Type or Print) <u>Samuel Thomas Davis</u>		4. DATE OF DEATH (Month) <u>June</u> (Day) <u>1</u> (Year) <u>1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>None</u>	8. DATE OF BIRTH <u>Sept. 10 - 1931</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>School Boy</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	9. AGE last birthday <u>19</u> yrs. If under 1 year Months Days Hours Min.
11. FATHER'S NAME <u>Alma J. Davis</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. MOTHER'S NAME <u>Hattie Hart</u>		14. MOTHER'S MAIDEN NAME <u>Hattie Hart</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Powellville Md.</u>	
17. INFORMANT <u>Mr. Alma J. Davis (Father)</u>			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION <u>Powellville Md.</u>	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause		(a) <u>Carcinoma of Rectum et Colon sec D</u>	<u>1 yr.</u>
154X Antecedent cause(s)		(b) <u>Papillomatous Polyps of Colon et Sigmoid</u>	<u>3 yrs.</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		(c) <u>Pulmonary and Hepatic metastases</u>	<u>6 mo.</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		<u>Emaciation and Cachexia sec D above</u>	
19a. DATE OF OPERATION <u>Nov. 1950</u>	19b. MAJOR FINDINGS OF OPERATION <u>Carcinoma of Colon & Rectum with Pulmonary & Hepatic metastases</u>	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN) <u>Powellville</u>	(STATE) <u>Md.</u>
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from Jan 1950 to June 1951, that I last saw the deceased alive on June 1, 1951, and that death occurred at 7:20 P.M. from the causes and on the date stated above.

SIGNATURE <u>Edmund R. Rabbitts M.D.</u>	DATE SIGNED <u>June 5, 1951</u>
23. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>	DATE <u>June 3-51</u>
NAME OF CEMETERY OR CREMATORY <u>St. James Cem.</u>	LOCATION (City, town, or county) (State) <u>Powellville Md.</u>
DATE REC'D BY LOCAL REG. <u>6/3/51</u>	24. FUNERAL DIRECTOR <u>Walter R. Holloman</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 11 1961
BUREAU OF THE U.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

06455

Reg. Dist. No. 351

1. PLACE OF DEATH: COUNTY <u>Monester</u> CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Snowhill Rural #2</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS		MARYLAND LENGTH OF STAY (On this place) <u>60 yrs</u>		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Maryland</u> COUNTY <u>Monester</u> CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Snowhill Rural #2</u> STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) <u>Marion</u> (First) <u>B.</u> (Middle) <u>Disharoon</u> (Last)		4. DATE OF DEATH <u>June</u> (Month) <u>20</u> (Day) <u>1951</u> (Year)			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Dec 14 - 1890</u>	9. AGE last birthday <u>60-6-8</u> yrs.	If under 1 year Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>gunham</u>		11. BIRTHPLACE (State or foreign country) <u>Snowhill, Md</u>	
13. FATHER'S NAME <u>Lewis B. Disharoon</u>		14. MOTHER'S MAIDEN NAME <u>Mar C. Garman</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT, AND ADDRESS <u>Mrs. B. C. Disharoon Snowhill, Md</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Carcinoma of Lung + metastasis

INTERVAL BETWEEN ONSET AND DEATH

6 mos?

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

Diabetes Mellitusmany yrs

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

none

19b. MAJOR FINDINGS OF OPERATION

none

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.)
INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY
m.INJURY OCCURRED
While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6-20, 1951, to 6-20, 1951, that I last saw the deceasedalive on 6-20, 1951, and that death occurred at 10:50 a.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Houck & Bolton, M.D.Willards, Md.6/21/51

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

June 23/51
Relay SmithWillards, Md.
Wiley C. Sumner Snowhill, Md

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 25 1934
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 354

06456

1. PLACE OF DEATH- COUNTY Worcester		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY Worcester	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Stockton		LENGTH OF STAY 40 years		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Stockton	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Rural				STREET ADDRESS (If rural, give location) Rural	
3. NAME OF DECEASED (Type or Print) Minnie		(First) B.		(Last) Miles	
5. SEX Female		6. COLOR OR RACE White		4. DATE OF DEATH June 7, 1951	
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married		8. DATE OF BIRTH Dec 16, 1880		9. AGE last birthday 70 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Virginia	
13. FATHER'S NAME John W. Bundick		14. MOTHER'S MAIDEN NAME Emma Shrieves		12. CITIZEN OF WHAT COUNTRY? US	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Year, no. or unknown) No		16. SOCIAL SECURITY No. None		17. INFORMANT AND ADDRESS Robert Miles, Stockton, Md.	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
(a) Immediate cause Acute Pulmonary Edema		2 Hrs.
(b) Antecedent cause(s) Disease or conditions, if any, giving rise to the above cause stating the underlying cause last Hypertensive Cardiovascular Renal Disease.		10 yrs
(c) OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Hemiplegia - 1 year		1 yr.

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?	
				Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from June 1, 1951, to June 7, 1951, that I last saw the deceased alive on June 7, 1951, and that death occurred at 12:30 P.M., from the causes and on the date stated above.

SIGNATURE Joseph La Mar MD ADDRESS Shaw Hill DATE SIGNED 8/8/51

23. BURIAL, CREMATION, REMOVAL (Specify) Burial		DATE THEREOF 6/9/51		NAME OF CEMETERY OR CREMATORY Gumby Memorial Cem.		LOCATION (City, town, or county) (State) Stockton, Md.	
DATE REC'D BY LOCAL REG June 9, 1951		REGISTRAR'S SIGNATURE Mary M. Taylor		24. FUNERAL DIRECTOR Henry H. Watson, Pocomoke, Md.		ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JUN 13 1961

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 355

06457

1. PLACE OF DEATH COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Delaware</u> COUNTY <u>Dessel</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Berlin</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Seelyville</u>	
TOWN <u>Berlin</u> LENGTH OF STAY (in this place) <u>6 months</u>		TOWN <u>Seelyville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) <u>Lottie</u> (First) (Middle) <u>Mumford</u> (Last)		4. DATE OF DEATH (Month) <u>June</u> (Day) <u>10</u> (Year) <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>1-31-1915</u>
9. AGE last birthday <u>36</u> yrs.		10. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Day Laborer</u>		11b. KIND OF BUSINESS OR INDUSTRY <u>Chicken factory</u>	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <u>John Bill Townsend</u>	
14. MOTHER'S MAIDEN NAME <u>Cora Books</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	
16. SOCIAL SECURITY No. <u>222-07-2726</u>		17. INFORMANT AND ADDRESS <u>Otto Mumford</u>	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Carcinoma of Uterus c</u>			<u>8 mo</u>
Antecedent cause(s) (b) <u>Generalized Metastases</u>			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Cachexia and above</u>			<u>3 mo</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION <u>Jan 51</u>		19b. MAJOR FINDINGS OF OPERATION <u>Cu 7 Uterus c Gen. metastases</u>	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT (Specify) <u>None</u>		22. PLACE (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	
SUICIDE		(CITY OR TOWN) (COUNTY) (STATE)	
HOMICIDE			
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from Nov, 1950, to 10 June 1951, that I last saw the deceased alive on 10 June 1951, and that death occurred at 2:30 P.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) Herbert A. Kallman M.D. ADDRESS Berlin, Md. DATE SIGNED 11 June 51

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE <u>June 12, 1951</u>	NAME OF CEMETERY OR CREMATORY <u>Sarah Dukes</u>	LOCATION (City, town, or county) <u>Bishop</u> (State) <u>Md.</u>
DATE REC'D BY LOCAL REG. <u>6/12/51</u>	REGISTRAR'S SIGNATURE <u>Helen F. Hayward</u>	24. FUNERAL DIRECTOR <u>Henry L. Watson</u>	ADDRESS <u>Pocomoke City, Md.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A17

820105

RECEIVED
JUN 18 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

06458

Reg. Dist. No. 3.55

The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH- COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Worcester</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Berlin</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Berlin</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) <u>RFD.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Sewell</u>	(Middle) <u>Wesley</u>	(Last) <u>Quillen</u>
4. DATE OF DEATH	(Month) <u>June</u>	(Day) <u>3</u>	(Year) <u>1957</u>
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>	8. DATE OF BIRTH <u>Mar 6, 1880</u>
9. AGE last birthday <u>71</u> yrs.	If under 1 year Months <u></u> Days <u></u>	If under 24 hrs. Hours <u></u> Mins. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Corn Farm</u>	
11. BIRTHPLACE (State or foreign country) <u>Berlin Md</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>Charlie Quillen</u>		14. MOTHER'S MAIDEN NAME <u>Mary Ellen Jones</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY No. <u>no</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Sewell Quillen Berlin Md</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Cerebral Thrombosis

INTERVAL BETWEEN ONSET AND DEATH

3 hours

Antecedent cause(s)

(b)

Bronchitis with acute failure chronic.3 years

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

Chronic prostatic hypertrophy6 months.II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) <u>No</u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u></u>	(CITY OR TOWN) <u></u>	(COUNTY) <u></u>	(STATE) <u></u>
TIME (Month) (Day) (Year) (Hour) OF INJURY <u></u>	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR? <u></u>		

22. I hereby certify that I attended the deceased from 1947, 19....., to June 3, 1957, that I last saw the deceased alive on June 2, 1957, and that death occurred at 1:00 A.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>6/5/57</u>	NAME OF CEMETERY OR CREMATORY <u>Daytonville</u>	LOCATION (City, town, or county) <u>Berlin</u>	(State) <u>Md</u>
DATE REC'D BY LOCAL REG. <u>6/5/57</u>	REGISTRAR'S SIGNATURE <u>Eileen F. Hayward</u>	24. FUNERAL DIRECTOR <u>Anna D. Burroughs</u>	ADDRESS <u>Berlin Md</u>	

VS. AT 5

100105

RECEIVED
JUN 11 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 353

06459

The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Worcester</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Bishopville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Bishopville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) <u>No #</u>	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
(First) <u>Paul</u> (Middle) <u>Collins</u> (Last) <u>Rayne</u>		(Month) <u>June</u> (Day) <u>21</u> (Year) <u>1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. <u>Married</u>	8. DATE OF BIRTH <u>May 14, 1896</u>
9. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Merchant</u>		10. KIND OF BUSINESS OR INDUSTRY <u>Owns own store</u>	9. AGE last birthday <u>55</u> ym.
11. BIRTHPLACE (State or foreign country) <u>Bishopville Md.</u>		12. CITIZEN-OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Lennie E. Collins</u>		14. MOTHER'S MAIDEN NAME <u>Tomothy N. Rayne</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war in which served) <u>None</u>		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Bill Rayne, Berlin, Md.</u>			

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Cerebral Hemorrhage</u>			<u>6 hrs</u>
Antecedent cause(s) (b) <u>Arterio-sclerosis</u>			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>None</u>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)	
TIME (Month) (Day) (Year) (Hour)		INJURY OCCURRED	
		While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			

22. I hereby certify that I attended the deceased from April....., 1948., to June 21....., 1951., that I last saw the deceased alive on 6-21-1951., and that death occurred at Bishopville Md., from the causes and on the date stated above.

SIGNATURE (Degree or title) Chas. R. Low, M.D. ADDRESS Berlin, Md. DATE SIGNED June 21 - 1951

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Removal</u>	<u>June 23, 1951</u>	<u>I.O.O.F.</u>	<u>Bishopville</u>	<u>Md.</u>
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR ADDRESS		
<u>June 21, 1951</u> <u>Mrs. A. Roy Berger</u>		<u>John Whaley</u> <u>Bishopville Md.</u>		

2906th Bishopville Del.

RECEIVED
JUN 25 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 06460 350

1. PLACE OF DEATH- COUNTY <u>Montgomery</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Pocahontas</u> TOWN <u>Pocahontas</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Home</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Md.</u> COUNTY <u>Montgomery</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Pocahontas</u> TOWN <u>Pocahontas</u> STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) <u>Larry</u>	(Middle) <u>Thomas</u>	(Last) <u>Shannon</u>
5. SEX <u>M</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>11/15/1897</u>
9. AGE last birthday <u>63</u> yrs.		4. DATE OF DEATH	(Month) <u>6</u> (Day) <u>26</u> (Year) <u>1951</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>County Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Public Works</u>	
11. BIRTHPLACE (State or foreign country) <u>Parkley Va</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Benjamin Shannon</u>		14. MOTHER'S MAIDEN NAME <u>Lucy Hickman</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY No. <u>205-100-105</u>	
17. INFORMANT AND ADDRESS <u>L. Shannon Jr. Pocahontas Va.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Acute Coronary Occlusion

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Cardio-vascular Disease with

(c) mild Coronary Thrombosis

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

Obese

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1947, 19....., to June 26, 1951, that I last saw the deceased

alive on June 26, 1951, and that death occurred at 11:30 P.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

June 28, 1951

Anne E. White

Parkley Va. 100105

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A157

RECEIVED
JUL 2 1961
RECEIVED A. J.

06461

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 350

1. PLACE OF DEATH- COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Worcester</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Pocomoke</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Pocomoke</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Route 2</u>		STREET ADDRESS (If rural, give location) <u>Route 2</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>James</u>	(Middle) <u>H.</u>	(Last) <u>Teagle</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>March 1869</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm Owner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Agriculture</u>	9. AGE last birthday <u>82</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>Nace Teagle</u>		14. MOTHER'S MAIDEN NAME <u>Jane Shields</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>None</u>		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Upshur Teagle, Rt 2, Pocomoke, Md.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Chronic Myocarditis

INTERVAL BETWEEN ONSET AND DEATH

1 year

Antecedent cause(s)

(b)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

Chronic Nephritis1 year

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.)
INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour)
OF INJURY

m.

INJURY OCCURRED
While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from March 1951, to June 17, 1957, that I last saw the deceased alive on June 16, 1957, and that death occurred at 8:30 A.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

June 22, 1951Anne E. WhiteHenry H. Watson, Pocomoke, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

FVS

100105

RECEIVED
JUN 25 1951
BUREAU V. S.

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 351

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MD</u> COUNTY <u>Worcester</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Snow Hill Rural</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Snow Hill</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Morris St</u>		STREET ADDRESS (If rural, give location) <u>Morris Street</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Henry</u>	(Middle) <u>Lee</u>	(Last) <u>Trelghman</u>
4. DATE OF DEATH	(Month) <u>June</u>	(Day) <u>28</u>	(Year) <u>1971</u>
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH
9. AGE last birthday <u>25</u> yrs.		If under 1 year: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Warehouse manager</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Oil</u>	
11. BIRTHPLACE (State or foreign country) <u>Salisbury, Md</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>David H. Trelghman</u>		14. MOTHER'S MAIDEN NAME <u>Clarence J. Green</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>217-124990</u>	
17. INFORMANT AND ADDRESS <u>Albert Trelghman, Son</u>		18. MEDICAL CERTIFICATION <u>Snow Hill</u>	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>Missing Hemorrhage (Cerebral)</u>		<u>minutes</u>	
Antecedent cause(s) (b) <u>due to compound fractures of skull</u>			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>result of auto accident</u>			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, office bldg., etc.) INJURY <u>Yard</u>	
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>June 28 1971 6:40 a.m.</u>		HOW DID INJURY OCCUR? <u>Automobile in which he was a passenger</u>	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input checked="" type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .			
SIGNATURE <u>Dr. H. E. Gorman</u>		DATE SIGNED <u>June 30 1971</u>	
23. DEATH BY CREMATION <input type="checkbox"/> OR BURIAL <input checked="" type="checkbox"/> (Specify)		NAME OF CEMETERY OR CREMATORY <u>Parson</u>	
DATE REC'D BY LOCAL REG. <u>6-30-71</u>		FUNERAL DIRECTOR <u>Way E. Vannit</u>	

MARGIN RESERVED FOR BINDING

RECEIVED
JUL 3 1951
BUREAU A. S.

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

06462

351

Reg. Dist. No.

1. PLACE OF DEATH COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>N. J.</u> COUNTY <u>Bergen</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Marble Hill</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Closter</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Washington St</u>		STREET ADDRESS (If rural, give location) <u>Red Oak Road</u>	
3. NAME OF DECEASED (Type or Print) <u>Edward Hatch Titus</u>		4. DATE OF DEATH (Month) <u>June</u> (Day) <u>30</u> (Year) <u>1951</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. BIRTH <u>Oct 11 1893</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Book Binder</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Wall Store</u>	9. AGE last birthday <u>58</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>N. Y. City</u>		12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>	
13. FATHER'S NAME <u>Edward Hatch Titus</u>		14. MOTHER'S MAIDEN NAME <u>Emily Fisher</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY No. <u>091-23-618</u>	
17. INFORMANT AND ADDRESS <u>Edgar Titus</u>		18. MEDICAL CERTIFICATION	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
Immediate cause (a) <u>Probably Coronary Disease</u>			
Antecedent cause (b) <u>420.1 94a</u>			
2. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death <u>Father's Grandfather died same way</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. TIME (Month) (Day) (Year) (Hour) OF INJURY		PLACE (Home, farm, factory, street, office bldg., etc.) INJURY HOW DID INJURY OCCUR?	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> accident <input type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/>		SIGNATURE <u>N. J. Sartorius</u> DATE SIGNED <u>6/30/51</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Removed</u>		DATE THEREOF <u>July 1, 1951</u>	
NAME OF CEMETERY OR CREMATORY <u>Removed</u>		LOCATION (City, town, or county) (State) <u>Closter, Bergen, N. J.</u>	
DATE REC'D BY LOCAL REG. <u>6/30/51</u>		REGISTRAR'S SIGNATURE <u>Rebec Smith</u>	
24. FUNERAL DIRECTOR <u>Waymoss Snowell</u>		ADDRESS <u>Waymoss Snowell</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

06464

Reg. Dist. No. 357

The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH COUNTY <u>Worcester</u> MARYLAND				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md</u> COUNTY <u>Worcester</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill</u>				CITY (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill</u>			
TOWN <u>Hill</u>				TOWN <u>Hill</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural, give location)			
3. NAME OF DECEASED (Type or Print)		(First) <u>Jessie</u>		(Middle)		(Last) <u>Waters</u>	
5. SEX <u>M</u>		6. COLOR OR RACE <u>C</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify)		8. DATE OF BIRTH <u>9/14/23</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY	
<u>Laborer</u>		<u>Smithy</u>		<u>Snow Hill, Md</u>		<u>USA</u>	
13. FATHER'S NAME <u>Carrie James Waters</u>				14. MOTHER'S MAIDEN NAME <u>Lydia Jones</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY No.		17. INFORMANT AND ADDRESS	
						<u>James Waters - Brother of decedent</u>	
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
Immediate cause (a) <u>Hemorrhage Lung</u>							
Antecedent cause(s) (b) <u>due to stab wound - (lower left lobe)</u>							
Disease or conditions, if any, giving rise to the above cause stating the underlying cause last							
<u>Result of Argument & Fight</u>							
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING <input type="checkbox"/>				PLACE (Home, farm, factory, street, office, hotel, etc.) (CITY OR TOWN) (COUNTY) (STATE)			
CAUSE OF DEATH.				<u>Snow Hill Worcester Md</u>			
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>June 23 1951</u>				INJURY OCCURRED <u>While at work</u> DID INJURY OCCUR? <u>at work</u>			
				<u>Stab wound on back during a fight</u>			
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .							
SIGNATURE <u>Dr. N. S. Gutierrez</u>				DATE SIGNED <u>6/24/51</u>			
(Degree or title)				ADDRESS <u>Pocomoke City, Md</u>			
23. FUNERAL, CREMATION OR BURIAL (Specify)				NAME OF CEMETERY OR CREMATORY			
DATE THEREOF <u>June 27/51</u>				<u>Worcester Md</u>			
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE <u>6/25/51</u>				24. FUNERAL DIRECTOR <u>Oliver J. Smith</u>			
REG.				ADDRESS <u>Snow Hill Md</u>			

970406

RECEIVED
JUL 3 1951
BUREAU A. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 350

06465

1. PLACE OF DEATH- COUNTY Worcester MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY Worcester	
CITY (If outside corporate limits, write RURAL and OR give nearest town) Pocomoke		CITY (If outside corporate limits, write RURAL and give nearest town) Pocomoke	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Second St.		STREET ADDRESS (If rural, give location) Second St.	
3. NAME OF DECEASED (Type or Print)	(First) Indiana	(Middle) -	(Last) Wilkerson
5. SEX	Female	6. COLOR OR RACE	White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	Married	8. DATE OF BIRTH	May 24, 1874
9. AGE last birthday	77 yrs.	10. KIND OF BUSINESS OR INDUSTRY	Home
11. BIRTHPLACE (State or foreign country)	Maryland	12. CITIZEN OF WHAT COUNTRY?	US
13. FATHER'S NAME	William Outten	14. MOTHER'S MAIDEN NAME	Mary F. Watson
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	No	16. SOCIAL SECURITY No.	None
17. INFORMANT AND ADDRESS	Bertha Lambertson, Pocomoke, Md.		

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Gangrene, right foot

INTERVAL BETWEEN ONSET AND DEATH

10 days.

Antecedent cause(s)

(b)

Arteriosclerosis, generalized.

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

Diabetes Mellitus

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office hldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug. 50, 1950, to June 25, 1951, that I last saw the deceased

alive on June 25, 1951, and that death occurred at 6:00 p.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Charles W. Trader, M.D.

Pocomoke City, Md.

June 26, 1951

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

June 27, 1951

Anne E. White

Henry H. Watson, Pocomoke, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JUL 2 1951
BUREAU A. B.